



# Tobacco Cessation Leadership Network

*Bringing Everyone Together Project*

## Facts about Smoking and Mental Health Disorders

- ✓ • Rates of smoking are 2-4 times higher among people with psychiatric disorders and substance use disorders.<sup>1</sup>
- Nearly 41% of current smokers report having a mental health diagnosis in the last month.<sup>2</sup>
- 60% of current smokers report a past or current history (ever history) of a mental health diagnosis sometime in their lifetime.<sup>1</sup>
- When seeking mental health treatment, heavy smokers report substantially poorer well-being, greater symptom burden, and more functional disability compared to nonsmokers.<sup>3</sup>
- Public mental health clients have a higher relative risk of death than the general population due, in part, to high rates of tobacco use.<sup>4</sup>
- Among current smokers, the most common **current** (within the last 30 days) mental health diagnoses are:<sup>2</sup>
  - Alcohol abuse
  - Major Depressive Disorder
  - Anxiety disorders: simple phobias and social phobias
  - Substance Abuse
- Among current smokers, the most common **ever** history of mental health diagnoses are:<sup>2</sup>
  - Alcohol abuse
  - Major depression
  - Substance abuse
  - Anxiety disorders: simple phobias and social phobias.
- Quit rates among smokers with any **current** mental health diagnosis are significantly lower than smokers with no history of mental illness.<sup>2</sup>
- Quit rates among smokers with **any history** of alcohol and substance abuse and social phobias are significantly lower than smokers without this history.<sup>2</sup>
- Quit rates among smokers with a past history of major depression and simple phobias are similar to smokers without this history.<sup>2</sup>
- Multiple explanations have been offered for the high rate of smoking among people with mental illness.<sup>1,5,6</sup>

- Genetic basis: Shared genetic factors have been identified for nicotine dependence and for depression. Genetic factors likely contribute to the development of schizophrenia and may be contribute to the development of nicotine dependence.
  - Self-medication: Some researchers speculate that the positive reinforcing effects of tobacco may help manage adverse events due to use of psychotropic medications.
  - Psychological factors: Smokers with many psychiatric disorders report that smoking reduces their psychiatric symptoms. These smokers are more likely to have higher nicotine dependence levels, have a current history of depression, ADHD, or alcohol dependence.
  - Trauma: Recent studies have linked a history of grief and PTSD with increased substance use including smoking. In some studies, smokers were found to be more likely to have a history of childhood trauma, which may link to adult depression. Therefore, the initial trauma rather than the later depression could be the risk factor for nicotine dependence.
  - Social factors: Limited education, poverty, unemployment, peers and the mental health treatment system where tobacco use is generally tolerated and not seen as a health issue may account, in part, for heavier smoking in this population.
- Key factors in the treatment of smokers with mental illness.
    - Under-treatment
      - Smokers with a mental health disorder are more likely to receive tobacco dependence treatment in a mental health setting and more likely to receive treatment from a primary care provider.<sup>7</sup>
      - All individuals with mental health disorders should be asked if they are smokers and advised to quit. All identified smokers should have smoking cessation integrated into their overall treatment plan.<sup>3,8,9</sup>
    - Timing
      - There is debate but no clear guidelines about when treatment for nicotine dependence should be introduced during treatment from psychiatric disorders. There is increasing evidence that nicotine dependence treatment does not jeopardize recovery from alcohol and other substances and may improve outcomes.<sup>7,8,9</sup>
      - There are emerging recommendations to treat the mental disorder first before attempting to treat nicotine dependence.<sup>3,9</sup>
    - Monitoring psychiatric symptoms
      - There are some reports in the literature indicating that psychiatric symptoms can worsen during the acute stages of

withdrawal when individuals are not taking pharmacological treatments for nicotine dependence.<sup>5,8,9</sup>

- There are also reports in the literature indicating that risk for major depression among patients with any history of major depression, increases through the first months following abstinence.<sup>5,11,12,13</sup>
- Psychiatric medications
  - Abstinence from nicotine can increase medication blood levels and risks for medication related adverse events. It is sometimes difficult to distinguish untreated withdrawal symptoms from adverse events from other medications precipitated by a sudden reduction or cessation of nicotine dosing. Therefore, patient monitoring during withdrawal should include consideration of dose adjustments.<sup>5,8,9</sup>
- Behavioral interventions:
  - There may be a need for more skill development in motivational interviewing and general smoking cessation skills.<sup>1,9</sup>
  - Protocols for treatment of smokers with mental illness exist for patients seen in mental health facilities and clinics. These protocols rely on prior knowledge of the smoker's diagnosis, medication history, and training to monitor symptoms and make medication adjustments.<sup>8</sup>
  - Protocols for smokers with a history of mental illness who seek tobacco dependence treatment in settings other than mental health facilities and clinics would follow standard tobacco dependence treatment guidelines. Adjustments in these protocols are needed to take into account special risks to achieving abstinence if we are to improve treatment of smokers with a history of mental illness.<sup>14</sup>

## References

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